REPORT

OF THE

WORKING GROUP

ON

BRIDGEWATER STATE HOSPITAL

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August 10, 1987

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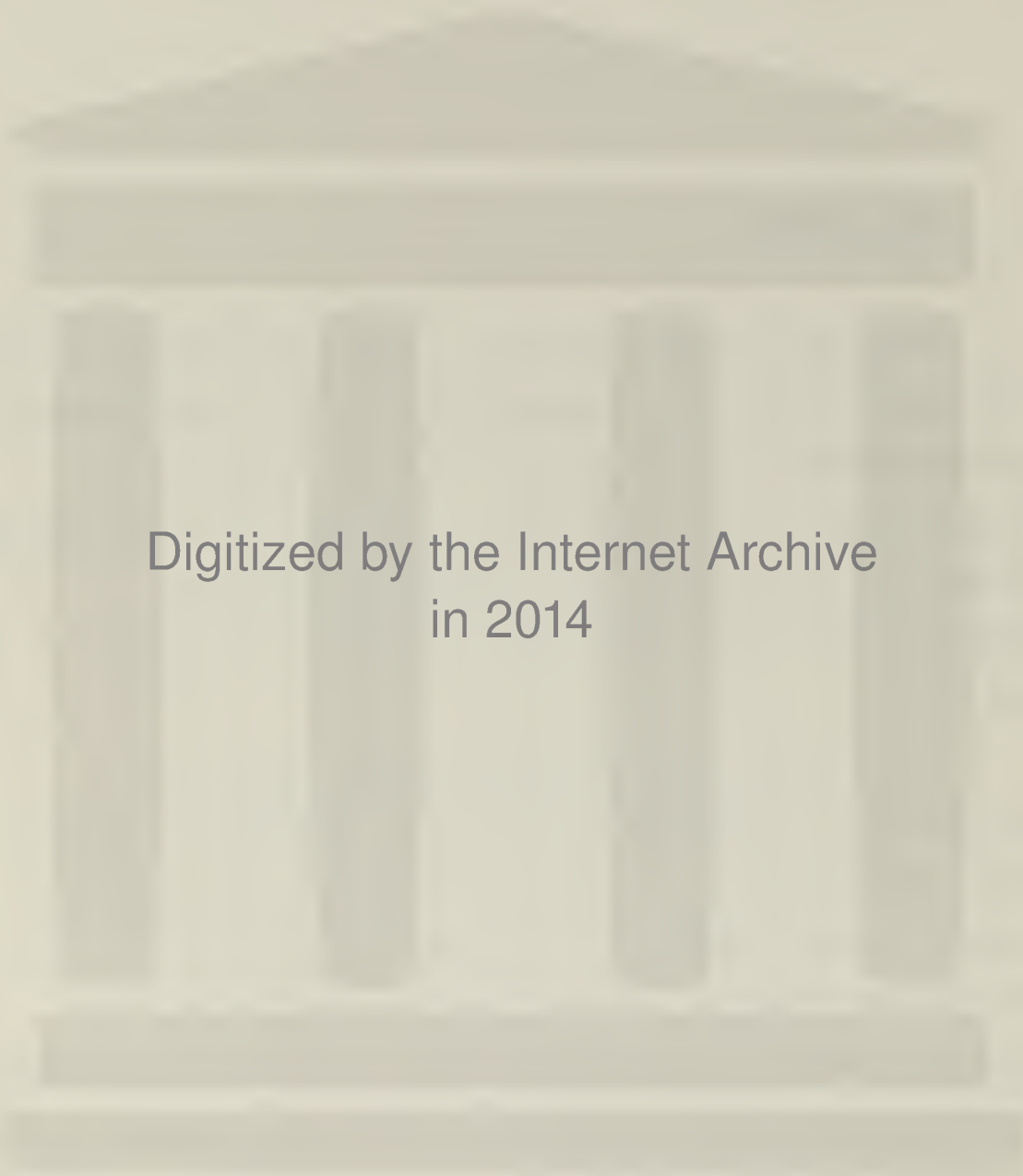
I. INTRODUCTION

Bridgewater State Hospital is the only maximum security psychiatric facility in Massachusetts and is administered by the Department of Correction. As such, Bridgewater is responsible for the evaluation, treatment, care and custody of men who are mentally ill, dangerous and need hospitalization in conditions of maximum or "strict" security.

As with Department of Mental Health facilities, Bridgewater is governed by the civil commitment statute, Mass. General Laws, c. 123, Sec. 1 et seq. The statute authorizes the admission to Bridgewater of mentally ill, violent men from (1) District and Superior Courts for pre-trial and post-trial evaluatons, (2) county correctional facilities and state prisons where they are awaiting trial or serving criminal sentences; and (3) Department of Mental Health facilities.



In the past few years, Bridgewater has received more than 1200 admissions annually, with the daily patient population fluctuating between 405 and 520 patients. Of these 1200 annual admissions to Bridgewater, approximately 45% are transferred to Bridgewater from the courts for pre-trial and post-trial evaluations; another 45% are transferred from county houses of correction and state prisons; and approximately 10% are transferred from Department of Mental Health facilities. On any given day, approximately 40% of the patient population is hospitalized pursuant to pre-trial observations and commitments, 38% from prisons and houses of correction, and 22% from Department of Mental Health facilities. Approximately two-thirds of the daily population at any given time is on commitment status, and one-third on observation status. At any given time, approximately 63% of the patients have had at least one prior admission to the hospital.

In recent months, the average daily census at Bridgewater has ranged from 405 to 420. These men comprise approximately 15% of the total number of inpatients currently at state psychiatric facilities, and approximately 23% of all male inpatients currently hospitalized in the

state mental health system. As the institution which serves as the "end of the line" for the court system, county and state correctional facilities, and public mental health system, Bridgewater must evaluate, treat and provide a safe and secure environment for the Commonwealth's most severely disordered and violent men. Thus, with only the most difficult of those who come before the criminal justice and public mental health systems referred to Bridgewater, it should not be surprising that approximately 70% of the patients have committed or have been charged with violent acts against other persons. Approximately 50% of all patients admitted to Bridgewater exhibit suicidal tendencies. Moreover, approximately 87% of the patients require and receive neuroleptic medication to treat their mental disorders.

Although Bridgewater is characterized as a correctional facility under M.G.L. c. 125 s. 18, it differs significantly from other state correctional facilities in its character, population, and purpose. Indeed, in these respects, Bridgewater is substantially more closely akin to Department of Mental Health facilities with the additional complicating factor of Bridgewater's special safety and security needs.

Unlike their prison and house of correction counterparts, patients at Bridgewater are committed to the hospital primarily for the purpose of receiving evaluation and treatment for mental illness, rather than to serve a criminal sentence. Thus, in order for a person to be involuntarily committed to Bridgewater, the Commonwealth must prove beyond a reasonable doubt at a civil court hearing that (1) the person is mentally ill; (2) the person is not a proper subject for commitment to any facility within the Department of Mental Health; and (3) the failure to retain the person in strict custody would create a likelihood of serious harm. When any of these elements can no longer be proven, a patient must be released from Bridgewater. A person may only be civilly committed to Bridgewater for a maximum period of six months in the first instance, and for a maximum period of one year for each subsequent commitment. Clearly, the "mixed" nature of the Bridgewater patient population, whose commonality lies both in their need to be hospitalized and in society's need to isolate the dangerous mentally ill individuals, distinguishes Bridgewater in both orientation and purpose from traditional correctional and mental health institutions.

Changes in mental health and criminal justice policies over the past few years have further challenged Bridgewater's ability to meet its goals of providing quality forensic and mental health treatment services in a safe and secure environment to the Commonwealth's most difficult and needy patients. Bridgewater is only one component in the elaborate state network of criminal justice and mental health service providers. Bridgewater has been the facility of last resort for the most difficult individuals in each of these systems. Bridgewater can only be as effective as the systems which rely on it, and any pressures experienced by these other systems will directly or indirectly have a significant impact at Bridgewater. For example, if a particular county house of correction is in the midst of severe overcrowding, that facility becomes less capable of maintaining its own difficult inmates, and thus more likely to refer these individuals to Bridgewater.

Among the legal changes which have significantly affected the administration and provision of services at Bridgewater over the past few years are the decision in the DMH case of Rogers v.Commissioner, which requires an adjudication of incompetency and substituted judgement prior to the administering of antipsychotic medication to patients who present a question of competency. And the current seclusion and restraint law which places strict limits on their use. Most recently, the Board

of Registration for Medicine promulgated new regulations requiring Massachusetts hospitals to establish formal Quality Patient Care Assurance Programs (QPCAP's), which will necessitate the development of quality assurance, peer review, and risk management procedures similar to programs in more traditional psychiatric hospitals.

Bridgewater is a complex institution dealing with some of the most difficult mentally ill men in the Commonwealth. In the Doe v. Gaughan case, the Federal courts in 1985 and 1986 judged that Bridgewater provides constitutionally adequate mental health services to its patients. The Working Group feels that with the broad and comprehensive improvements now occurring in the Commonwealth's mental health system, we now have the opportunity to raise Bridgewater to an even higher standard of care.

Since March 1987, there have been five deaths at Bridgewater, three of which were determined to be suicides and one of which occurred while the patient was in restraint. The Secretary ordered the EOHS Investigative Unit to conduct a thorough investigation of the deaths. Because these deaths raised larger questions about the conditions at Bridgewater, Secretary Johnston last May convened a Working Group chaired by EOHS Undersecretary John Mudd and including the Commissioners of DOC and DMH as well as senior staff from EOHS and both agencies. The group was

given a 90-day mandate to review staffing patterns, management structure, and treatment programs at the State Hospital and to make recommendations which would improve the quality of mental health services and security offered at Bridgewater in both the short and long terms.

II. RECENT HISTORY 1985-1987

While there are many problems in the operation and management of Bridgewater, much has been done by the staff under extraordinarily difficult circumstances to improve treatment, services, and safety at the facility. Since 1985 there have been significant changes at the hospital which have improved the conditions in which care is provided to the patients at Bridgewater.

Population and Staffing Levels

- The census has been reduced from over 520 in 1985 to a range of 405 to 420 in recent days.
- The number of correctional officers assigned to the hospital has increased from approximately 200 in 1985 to 225 today.
- The levels of authorized clinical staff have been increased from 35 FTEs in FY86 to 41 FTEs this year. Thirty-six of these 41 FTEs are filled today, including 9.8 of 10 FTE psychiatrist positions.
- The combined effect of these improvements has been to reduce the patient to clinical staff ratio from 16:1 in 1984 to 12:1 today.

III. IMPROVEMENTS NOW UNDERWAY AT BRIDGEWATER

In addition to the improvements already achieved during the past two fiscal years, the Administration proposed and the Legislature approved additional resources to strengthen staffing levels and provide new equipment for this fiscal year. $975,000 has been appropriated and changes are now being implemented.

Staffing Levels

- o $525,000 is committed for new treatment and program staff including occupational therapists and psychiatrists.
- o $150,000 is committed for additional nursing staff.
- o $300,000 is committed for new equipment and management staff, including:
  - A director of programs.
  - A supervisor of records.
  - An industrial shop manager and assistant shop manager to oversee vocational education.
  - A supervisor of housekeeping.
- o 30 additional Correction Officer "excess quota" positions will be added to bring the total staff complement back to current assigned levels by replacing those officers on extended sick leave and industrial accident leave.

Management

- To improve management and accountability, the Commissioner of Correction has created a new position and appointed a Hospital Administrator who is fully responsible for the operation of Bridgewater State Hospital. All personnel and contractors in the hospital will answer to the Administrator who reports directly to the Deputy Commissioner.

Treatment

- Written treatment plans are now being developed for all committed patients at Bridgewater.

- Treatment teams are meeting twice weekly to discuss the clinical progress of each patient.

Training

- The Bridgewater clinical staff has designed a 40-hour program on mental health issues for correction officers at the hospital, which is currently being implemented.

Maintenance

- Numerous improvements to the physical plant are now under study including replacement of plumbing fixtures, new floor covering, additional fire safety apparatus, and a new hot water pump. A new roof is nearly 50% complete.

IV. RECOMMENDED IMMEDIATE ACTION

Despite these steps, the EOHS Investigative Unit and the Working Group have found deficiencies in the care and monitoring of patients in seclusion and restraint, which require immediate action.

Seclusion and Restraint Monitoring Action Plan

- Funding should be immediately committed to staff 7 monitoring posts for 9 months (36FTEs). This reflects actual on-site surveys of the number of staff needed to assure that Specially Trained Observers (STOs) are in full view of those in seclusion and that each patient in restraint is visible to an STO, in accordance with recommendations of the EOHS Investigative Unit preliminary report on the death of Edward Roake.

- STOs should be mental health staff hired and specially trained to care for patients in seclusion and restraint.

- DOC, in consultation with EOHS, should continue to review and, if necessary, revise its regulations to assure effective monitoring of patients in seclusion and restraint in full compliance with the law.

- Bridgewater management staff should assure that the regulations, as reviewed, are fully implemented.

- SEE APPENDIX FOR DETAIL.

V. RECOMMENDATIONS FOR BRIDGEWATER FY88 to FY90

Bridgewater State Hospital should be staffed and operated as a mental health hospital with maximum security, consistent with the clinical and management standards established for the Commonwealth's mental health hospitals. This will require the infusion of significant resources, which should be phased-in over a three year period. The major components of this investment should be increased management, direct care, clinical, and program staff. Detailed implementation plans must deal with the following range of issues. Work is already underway on them.

Management Team

- The Commissioner of Correction has appointed a Hospital Administrator who will be the chief operating officer reporting directly to the Deputy Commissioner. In addition there must be a senior management team modeled on the new DMH hospital staffing patterns, with professional administrators in the following areas:
  - Medical and Psychiatric Services.
  - Patient Services.
  - Nursing Services.
  - Staff Development and Training.
  - Administrative and Core Services.
  - Quality Assurance.
  - Internal Investigation.

Clinical Staff

- The numbers of psychiatrists, psychologists and direct care mental health workers needs to be adjusted significantly to provide the quality of evaluation, treatment, and attention that the patients need under the standards of a modern mental health facility.

Program Staff

- There is not enough recreational or other activity for patients at Bridgewater, and too little opportunity for occupational and vocational therapy. Although some program staff are currently being hired, additional program resources will be necessary to meet mental health standards.

Nurses

- There is a continuing, serious gap in the number of nurses on duty at the facility. To the extent that recruitment problems can be overcome, additional nurses should be added this year, as well as in the future.

Correction Officers

- Bridgewater patients have special security needs. Mental health staffing patterns need to be adjusted to reflect this reality and, in addition to their outside security functions, special attention must be given to the question of how to integrate security personnel into patient housing and the treatment teams.

Space and Maintenance

- New maintenance staff are needed at the facility and leasing of modular units should be undertaken to provide essential program space. Given the revised population projections and staffing models, and in the context of changes in the mental health hospitals and county correctional facilities, a review of capital construction needs at Bridgewater must be undertaken.

VI. DMH ACTIONS AND FUTURE PLANS

Many patients currently at Bridgewater do not need to be in a maximum security environment. Some are inappropriately referred by the courts, some by state and county correctional facilities, and some by the Department of Mental Health. This is a complicated, longterm problem that will require carefully devised solutions. We need to work closely with the Courts and Sheriffs to develop answers. To start this course:

- DMH should develop a plan with county correctional officials to expand their joint capacity to conduct forensic evaluations and to provide mental health services to mentally ill county inmates in county correctional facilities.

- DMH should continue to develop its forensic mental health services so that forensic and clinical evaluations are available at each of the Commonwealth's trial courts to improve the screening of referrals to Bridgewater. It should work with court staff to inform them about the new forensic capability being developed at DMH and the types of populations to be served at Bridgewater.

- As part of the Governor's Mental Health Special Message, DMH will open two forensic evaluation units for men this year which will decrease inappropriate referrals to Bridgewater.

  - By late Fall 1987, DMH will open a 25-bed secure care forensic unit at Taunton State Hospital to evaluate mentally ill men.

  - By late Spring 1988, DMH will open a second 25-bed secure care forensic unit for men in the Boston or Worcester area.

- In the current 90-day planning process called for in the $369 million Mental Health Capital Outlay Budget, DMH will develop plans to establish 80 to 100 beds for patients who are chronically mentally ill and require hospitalization in a secure, but less than maximum secure, setting. The planning will consider the potential for utilizing modular construction units to speed-up the proposed construction process.

The combined result of improved screening procedures, expanded mental health services in county correctional facilities, these new DMH units, and more efficient DOC management is projected over the long-run to reduce Bridgewater's census to its design capacity of 320. At this level, staff-to-patient ratios will be improved and additional program space will become available.

VII. SUMMARY CONCLUSIONS AND RECOMMENDATIONS

- Funding should be allocated immediately to hire additional mental health staff so that Bridgewater can fully comply with the requirements of the seclusion and restraint law.

- Bridgewater State Hospital should be supported to fulfill its misson as a mental health hospital with special security needs. The management and staffing standards of the hospital should be developed on the current model now envisioned for DMH hospitals throughout the Commonwealth.

- The Department of Correction should continue to administer the hospital as a facility for those patients who need "strict" security.

- Steps should be taken to prevent the inappropriate referral to, and mixture of patients at, Bridgewater who may not need a maximum security environment.

  - The Departments of Mental Health and Correction should work together with court staff and Sheriffs to develop effective screening procedures for the courts as well as state and county correctional facilities to prevent inappropriate referrals.

  - The Department of Mental Health needs to continue to create a capacity to care for those patients who can function in a less secure environment and do not need the maximum security of Bridgewater. In addition, DMH should expand its ability both to provide mental health services in county correctional institutions and to carry out court based evaluations.

- In implementing these recommendations at Bridgewater State Hospital, the Department of Correction should:

  - Add clinical, program, and activity staff to treat the patients and to develop occupational and recreational therapy for them.

  - Increase training of management and staff in the new organization of the hospital and in the care and treatment of people who are mentally ill and violent.

  - Improve communication between patient families and the management and clinical staff.

  - Implement a number of necessary facility improvements. Additional program space should be added, through the leasing of a modular unit; new investment in capital improvements and equipment for the existing buildings needs to be undertaken; and DCPO should review the longterm construction requirements for the hospital.

VIII. FINAL COMMENTS

The recommendations of the Working Group outlined in this report are the beginning of a longterm process to upgrade Bridgewater State Hospital. Immediate action is necessary to comply with the seclusion and restraint monitoring requirements. The Department of Correction has already taken important steps to improve the management system and introduce new clinical and program staff as well as correction officers now. The development and implementation of detailed plans to raise the standards of Bridgewater to the proposed levels of mental health hospitals will take time. Similarly, the development of new screening procedures with the courts and new mental health services within the county correctional system will require careful consultation and planning with the Courts and Sheriffs. Finally, the construction of new DMH secure program facilities will not happen overnight. The principles and framework for solutions to the issues raised by Bridgewater are present. The commitment to action is present. And the process of implementing change is already starting.

ACKNOWLEDGEMENTS

The Working Group wishes to extend its thanks to the senior staff of EOHS and both departments who spent long hours helping to develop this report.

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SECLUSION AND RESTRAINT MONITORING/ BACKGROUND AND ACTION PLAN

I. Introduction

The Secretary directed in early May that the Working Group was to pay special attention to the care and monitoring of patients in seclusion and restraint, among other issues facing Bridgewater. The EOHS Investigative Unit also began its investigation into the deaths at Bridgewater with an investigation of the death of Edward Roake, the only patient to have died in restraint. Its Preliminary Report, issued July 6, 1987, established serious problems in the care and monitoring of persons in seclusion and restraint, including insufficient staff to monitor patients in seclusion on several units and found violations of seclusion and restraint statutes and regulations in the monitoring of Mr. Roake. Based on the Report's findings and recommendations, the Working Group has devised an Action Plan to assure effective care and monitoring of patients in seclusion and restraint in compliance with the law.

II. Background

Seclusion and restraint are widely accepted and effective means of treatment which are commonly used at public and private psychiatric hospitals. The purpose and effect of seclusion and restraint is to enable mentally ill persons who have lost control of themselves to regain their self-control. For example, placement in seclusion may be necessary when a person who is out of touch with reality believes that others are trying to kill him, and attacks others out of the false belief that it is necessary to protect himself. Likewise, mechanical restraints may be used where a patient who has physically hurt or mutilated himself in the past threatens to or does in fact engage in such self-destructive acts.

In April, 1985, the legislature imposed strict new requirements on all public and private psychiatric hospitals, including Bridgewater, regarding the use of seclusion and restraint. That law requires that seclusion or restraint may only be used in an emergency; that only the Superintendent, Medical Director or designated physician is authorized to order placement of a patient in seclusion or restraint; and that seclusion or restraint orders must be limited to three hours in duration. Most notably, the statute requires that a person specially trained "to understand, assist and afford therapy" to the patient (a specially trained observer, "STO") must be in attendance of any patient in seclusion or restraint.

The Preliminary Report on the death of Edward Roake, prepared by the EOHS Investigative Unit, found that, while there was sufficient staff on the night Roake was in restraint in the Medical Unit to monitor him, "staffing generally on the 11-7 shift was not sufficient to allow officers to be visible to all patients in seclusion in the Admissions and Max II Units while at the same time allowing them to respond to emergencies and maintaining a sufficient staffing level in the Medical Unit." Report at p. 19.

In particular, the Report found that in the Admissions Unit (where the vast majority of patients in seclusion were housed) "a single STO could not be visible to all patients in seclusion." Further, the Report found that there was no STO on the Max II Unit (which regularly housed patients in seclusion when Admissions and Medical Units were filled at that time) and that the only officer assigned on the 11-7 shift had other duties which "required him to be away from a position where he would be constantly visible to patients in seclusion" (with no other officer in the Unit to relieve him at the monitoring position). The Report recommended that the Working Group "should review staffing levels with consideration given to seeking additional resources for monitoring persons in seclusion and restraint." Id. at p. 20.

III. Action Plan

Based on the Report's careful findings and recommendations, the Working Group, in consultation with DOC and EOHS counsel, initiated a close, on-site analysis of the number of staff needed to assure effective monitoring of patients in seclusion and restraint in full compliance with the law. As part of the review, it was determined unnecessary to continue the use of Max II for seclusion.

Bridgewater now has two separate locations where patients are placed in seclusion or restraint, the Admissions Unit and the Medical Unit. The Admissions Unit, where most patients in seclusion are housed, is comprised of two corridors consisting of 20 rooms. The Medical Unit, where self-injurious patients are placed in restraint and "special needs" patients are placed in seclusion, is comprised of three corridors consisting of both dormitory and single rooms. Generally, seclusion and restraint occurs only on one corridor of the Medical Unit. (A diagram of the Admissions and Medical Units is attached.)

M.G.L. c. 123 s. 21 requires that an STO constantly be in full view of each patient in seclusion and that each patient in restraint be constantly visible to an STO. An actual room-by-room survey of the Admissions and Medical Units revealed that seven STO posts are required to meet these monitoring requirements. (The STO posts have been designated by an "X" on the attached diagram.)

Recommendation #1: In order to staff these seven posts 24 hours a day, seven days a week, it is necessary to fund 36 full time equivalent positions.

Since c. 123, s. 21 has been implemented at Bridgewater, correction officers have been responsible for serving as "specially trained observers" (STOs).

Recommendation #2: These STO positions should be filled by mental health workers under the current provider contract, who will have, at a minimum, a bachelor's degree in a mental health field and who will participate in a comprehensive training program on the clinical, legal and administrative aspects of seclusion and restraint. These seven clinically trained STO's will provide meaningful around-the-clock intervention to patients placed in seclusion or restraint due to their potential or actual assaultive or self-injurious behavior.

Recommendation #3: DOC Legal Counsel, in consultation with the EOHS General Counsel, should continue to review Bridgewater State Hospital regulations in this area with particular scrutiny on the following: (1) the standards for placement and continuation of patients in seclusion and restraint; (2) documentation of the basis for placement and continuation of patients in seclusion or restraint and STO monitoring; (3) training of STO's; (4) development of treatments which serve as alternatives to the use of seclusion and restraint; and (5) monitoring requirements.

IV. Conclusion

This Action Plan, we believe, will assure that the troubled and difficult patients at Bridgewater, when they require the special protection of placement in seclusion and restraint, are fully attended to and monitored in compliance with the law.

BRIDGEWATER STATE HOSPITAL

MEDICAL BUILDING